

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14039

CERTIFICATE OF DEATH

14042

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 38 yrs 3 mos 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 3914 Sixth St.	
3. NAME OF DECEASED (Type or print) First James Middle ALLEN Last ALLEN		4. DATE OF DEATH Month October Day 12 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 10 Days 12 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Allen - Deceased		14. MOTHER'S MAIDEN NAME Esther	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 215-544-935	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia, bilateral 10 to 14 days 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized debilitation associated with chronic psychosis DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 10 to 14 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 6-27-28, 19 , to 10-12-66, 19 , and that death occurred at 8:00p M, from causes and on the date stated above.			
22a. SIGNATURE Irina Reus M.D.		22b. DATE SIGNED 10-13-66	
22c. PHYSICIAN'S NAME (Type) IRINA REUS, M. D.		22d. ADDRESS VAH Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 10/18/1966	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR PENNINGTON & SON - Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

140041

March 30, 1944

140041

Subject:

Info:

Classification:

Ref: 100-100000

Date: 3/30/44

Re: 100-100000

Location: 100-100000

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14040

14043

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 202 Landing Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LET IT IA OTT BAKER		4. DATE OF DEATH Month Day Year October 8, 1966					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 13, 1891	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Peter Ott		14. MOTHER'S MAIDEN NAME Louisa Homiller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If any give war or dates of service)		17. INFORMANT Mrs. Mary Louise Perkins, Newark, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO (b) Pelvic phlebothrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rt humerus and olecranon						INTERVAL BETWEEN ONSET AND DEATH 2 days ? 4 days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell down three front steps 9-27-66		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9-27 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Elkton Cecil Md	
21. I certify that (I) (this hospital) attended the deceased from 10-7-1966 to 10-8-1966, and that (I) (we) last saw the deceased alive on 10-8-1966, and that death occurred at 3:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Williford Eppes		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/12/66	
22c. PHYSICIAN'S NAME (Type) Williford Eppes, M.D.		22d. ADDRESS 327 East Main St. Newark, Delaware					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/66		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town or county) (State) Bethel, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Nicks		ADDRESS Nicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 10 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS 106 Howard St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EMMA D. Middle BOYD Last 						4. DATE OF DEATH Month October Day 18 Year 19 66							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1884		9. AGE (in years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Thomas R. Davis						14. MOTHER'S MAIDEN NAME Jennie Rambo							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Robert A. Boyd			Address 106 Howard St. North East, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO (c) DISEASE												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 17 OCT , 19 66 , to 18 OCT , 19 66 , that (I) (we) last saw the deceased alive on 17 OCT , 19 66 , and that death occurred at 10 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Robert L. Gray						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 18 OCT 1966				
22c. PHYSICIAN'S NAME (Type) Robert L. Gray						22d. ADDRESS Elkton Medical Park, Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.			23d. LOCATION (City, town or county) (State) Colora Cecil Co. Md.					
24. FUNERAL DIRECTOR Grant Funeral Home						ADDRESS 188 North East, Md.			25a. REC'D BY REGISTRAR Charles Judge				
						DATE OCT 20 1966			25b. REGISTRAR'S SIGNATURE				

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STATEMENT OF DEBIT

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14042											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East				c. LENGTH OF STAY IN 1b 12yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East 07.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUSTUS Middle WARD Last BURR			4. DATE OF DEATH Month October Day 17 Year 19 66								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1895		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Owner				10b. KIND OF BUSINESS OR INDUSTRY Insulation		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Augustus W. Burr						14. MOTHER'S MAIDEN NAME Mary Erdman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 163 05 8134		17. INFORMANT Mrs. Elizabeth C. Burr, R. D. N. E. Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7440 Myasthenia Gravis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/17, 1966, to 10/17, 1966, that (I) (we) last saw the deceased alive on 10/17, 1966, and that death occurred at 4:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Klaus H. Huebner						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/66			
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER						22d. ADDRESS NORTH EAST, 2d					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Oct. 13, 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION (City, town or county) (State) 4000 Suitland Road, S.E. Washington, D.C.			
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Maryland						25a. REC'D BY REGISTRAR DATE OCT 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14043

14046

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Hartford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 6 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air			12-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 138 N. Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SILAS Winfield CAIN				4. DATE OF DEATH Month Day Year October 7 19 66				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-13-94		9. AGE (In years last birthday) yrs. 71	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney			10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (County & State, or foreign country) Forest Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Cain (D)				14. MOTHER'S MAIDEN NAME Charlotte Baldwin (D)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 215-56-4742		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic insufficiency with diffuse jaundice 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the liver DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1-2 months 6 mos.-1yr.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from October 1, 1966 , to October 7, 1966 , and that death occurred at 4:10 am from causes and on the date stated above.								
22a. SIGNATURE Irina Reus, M. D.				22b. DATE SIGNED Oct. 7, 1966		22c. PHYSICIAN'S NAME (Type) Irina Reus, M. D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF October 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Rock Spring Episcopal Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Forest Hill, Hartford Co., Maryland		
24. FUNERAL DIRECTOR Foster Funeral Home, Bel Air, Maryland				25a. REC'D BY REGISTRAR OCT 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14044					14047					
1. PLACE OF DEATH a. CDUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. CDUNTY Cecil					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					d. STREET ADDRESS R.D. # 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Violet			First Middle Last L. Chidester		4. DATE OF DEATH Month Day Year October 21 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1890		9. AGE (In years last birthday) 76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter Jones				14. MOTHER'S MAIDEN NAME Carvilla						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-7078B		17. INFORMANT Address 3 Md. Austin C. Chidester, Sr. Elkton,						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4200 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia, severe, type undetermined									INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from 10-3-1966, to 10-21-1966, that (I) (we) last saw the deceased alive on 10-21-1966, and that death occurred at 8:35 AM, from the causes and on the date stated above.				
22a. SIGNATURE Tillman D. Johnson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-24-66				
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson				22d. ADDRESS 123 Singler Ave, Elkton, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/25/66		23c. NAME OF CEMETERY OR CREMATORY BAY VIEW METHODIST CEMETERY		23d. LOCATION (City, town or county) (State) Bay View, Md.				
24. FUNERAL DIRECTOR Hugh E. Hicks				ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

11003

11003

INVESTIGATION OF DEATH

AMERICAN STATE BOARD OF HEALTH

U. S. DEPARTMENT OF HEALTH

REPORT OF

DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1210 12th St., N.W. Apt 22 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CLEMENTS		4. DATE OF DEATH Month Day Year October 28 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-92
9. AGE (In years lost birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver	
11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Clements (D)		14. MOTHER'S MAIDEN NAME Mary A. Willet (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-54-4726	
17. INFORMANT VA Hospital Records, Perry Point, Md.		18. ADDRESS VA Hospital Records, Perry Point, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Parkinson Disease DUE TO (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden 8-12 Mo. or 1 Yr -More	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from June 21 , 19 62 to October 28 , 19 66 , and that death occurred on October 28 , 19 66 , at 6:35 a.m. from causes and on the date stated above.			
22a. SIGNATURE Battis Singh, M.D.		22b. DATE SIGNED 10-28-66	
22c. PHYSICIAN'S NAME (Type) Battis Singh, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/1/1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR W. W. CHAMBERS FUNERAL HOME, WASHINGTON, DC		25. REC'D BY REGISTRAR OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14046

14049

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First EMMA		Middle ELIZABETH		Last COATS		4. DATE OF DEATH Month October		Day 7,		Year 19 66	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March, 17, 1917		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.				10b. KIND OF BUSINESS OR INDUSTRY Home.		11. BIRTHPLACE (County & State, or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Martin.						14. MOTHER'S MAIDEN NAME Margaret Cotton.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 1		17. INFORMANT James A. Coats,				Address Cecilton, Md. 21913			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute coronary occlusion with myocardial infarction and instant death													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jul		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 Oct , 19 66 to 7 Oct , 19 66 , that (I) (we) last saw the deceased alive on 7 Oct , 19 66 , and that death occurred at 7:00 AM on the causes and on the date stated above.													
22a. SIGNATURE Wallace Obenshain, M.D.												22b. DATE SIGNED 11 Oct 66	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.						22d. ADDRESS Cecilton, Md. 21913		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.				23b. DATE THEREOF Oct. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Cecilton Col. Cemetery				23d. LOCATION (City, town or county) (State) Cecilton, Cecil Co; Md.			
24. FUNERAL DIRECTOR Edward Fellows,						ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
2DM 1/65Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton</u>				d. STREET ADDRESS <u>Frenchtown Rd.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> <u>ELSWORTH CRESWELL SR.</u>						4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1966</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 17, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Thomas A. Creswell</u>						14. MOTHER'S MAIDEN NAME <u>Mary Tyson</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-09-8894</u>		17. INFORMANT <u>Laura J. Creswell</u>				Address <u>Elkton R.D. 2Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> <u>5271</u> DUE TO (b) <u>Cor Pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>chronic severe Emphysema</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6</u> , 19 <u>66</u> , to <u>Oct 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 18</u> , 19 <u>66</u> , and that death occurred at <u>5:44 AM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>Rolando A. Najera</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/18/66</u>									
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Najera</u>						22d. ADDRESS <u>Elkton, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct. 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Pk. Elkton, Md.</u>			23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>						ADDRESS <u>Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14048

CERTIFICATE OF DEATH

14051

1. PLACE OF DEATH a. COUNTY Cecil County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 47 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.				d. STREET ADDRESS 1113-7th Street, NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Emanuel Day		4. DATE OF DEATH Month Day Year October 30 19 66					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH July 24, 1904	
9. AGE (In years last birthday) 62 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (County & State, or foreign country) Lee County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Emanuel Day				14. MOTHER'S MAIDEN NAME Emma Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 225-10-5108		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 454X Acute Pulmonary Edema DUE TO Congestive Heart Failure (b) Acute Tubular Nephrosis, both Kidneys DUE TO Common Iliac Artery (c) Thrombosis abdominal Aorta with extension into INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 days 2-10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (NAME) attended the deceased from 9-13-66, 19, to 10-30-66, 19, and that death occurred at 1:20 AM, from causes on and on the date stated above.							
22a. SIGNATURE Victor Victorius Jose Borges		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-30-66			
22c. PHYSICIAN'S NAME (Type) V. J. BORGES		22d. ADDRESS VAH, Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/3/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Ft. Myers, Va.	
24. FUNERAL DIRECTOR G. Hall		ADDRESS HALL BROTHERS FUNERAL HOME, Washington, D.C.		25a. REC'D BY REGISTRAR DATE NOV 2 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14049

CERTIFICATE OF DEATH

14052

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East			c. LENGTH OF STAY IN 1b 55 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 1				d. STREET ADDRESS R.D. 1			
3. NAME OF DECEASED (Type or print) MARTHA ELIZABETH GAMBLE				4. DATE OF DEATH Month October Day 17 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 15, 1888	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min. 17	IF UNDER 24 HRS. Months 7 Days 17 Hours 17 Min. 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Williams				14. MOTHER'S MAIDEN NAME Maryetta Mason			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 1810		17. INFORMANT Elita E. Gamble Address R.D. 1 Box 85 North East, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Urinary Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1810 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dietary Habits							INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State) ---			
21. I certify that (I) (this hospital) attended the deceased from May , 1946, to 17 Oct , 1966, that (I) (we) last saw the deceased alive on 30 Sept 1966, and that death occurred at 6 A. M, from causes and on the date stated above.							
22a. SIGNATURE Klaus H. Huebner				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/66	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER M.D.				22d. ADDRESS NORTH EAST Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/66	23c. NAME OF CEMETERY OR CREMATORY Bay View Cemetery		23d. LOCATION (City or Town) (County) (State) Bay View Cecil Md.		
24. FUNERAL DIRECTOR Grant Funeral Home				25a. REC'D BY REGISTRAR Box 22 North East, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14050

14053

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 26 days 1 yr 11 mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SARAH B. GARY		4. DATE OF DEATH Month Day Year October 7 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-23
9. AGE (In years last birthday) 43		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Clinton, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 579-24-8569	
17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Thrombophlebitis DUE TO (c) Generalized Skin Eruption (Chronic Neurodermatitis) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH Sudden Unk.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 16, 1964 , to October 7 1966 and that death occurred at 3:40 AM from causes and on the date stated above.			
22a. SIGNATURE B. Singh M.D.		22b. DATE SIGNED 10-8-66	
22c. PHYSICIAN'S NAME (Type) B. SINGH, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 10 7 66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Ft Myer, Virginia
24. FUNERAL DIRECTOR PENNINGTON & SON - Funeral Home - Grace, Md.		25a. REC'D BY REGISTRAR OCT 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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District of Columbia

Washington

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435 Maryland Street, NW

Washington, D.C. 20001

October 7

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Washington, D.C. 20001

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14051

CERTIFICATE OF DEATH

14054

1. PLACE OF DEATH a. CDUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cecilton d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DOROTHY		First DOROTHY Middle HAGGERTY Last HAGGERTY		4. DATE OF DEATH Month October Day 4 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16, 1902	9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joshua Reed.			14. MOTHER'S MAIDEN NAME Elizabeth Clark				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-36-8209		17. INFORMANT Miss, Myrtle Haggerty, Address Cecilton, Md. 21913			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) severe pyelonephritis, Arteriosclerotic heart disease.					INTERVAL BETWEEN ONSET AND DEATH one year		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug _____, 19 65 to 4 Oct _____, 19 66, that (I) (we) last saw the deceased alive on 4 Oct 19 66, and that death occurred at 6:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE Wallace Obenshain M.D.				22b. DATE SIGNED 6 Oct 66			
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.				22d. ADDRESS Cecilton, Md. 21913			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.		23b. DATE THEREOF Oct. 7, 1966		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery			
24. FUNERAL DIRECTOR Edward Fellows,		ADDRESS Millington, Md.		25a. REC'D BY REGISTRAR DATE OCT 10 1966			
25b. REGISTRAR'S SIGNATURE J. Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14052						14055					
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>9 MONTHS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION HOSPITAL</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u>			First Middle Last <u>Harasymczuk</u>			4. DATE OF DEATH <u>Oct 27 19 66</u>			Month Day Year		
5. SEX <u>female</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/5/1893</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>WOJNIAK</u>						14. MOTHER'S MAIDEN NAME <u>Annie? Wosnick</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>JOHN HARASYMCZUK - CITY, MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>recent myocardial infarction.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 27, 19 66</u> to <u>27 Oct, 19 66</u> , that (I) (we) last saw the deceased alive on <u>27 Oct 1966</u> at <u>8:10 pm</u> , and that death occurred at <u>8:10 pm</u> and on the date stated above.											
22a. SIGNATURE <u>Wallave Obenshain</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>28 Oct 66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Wallave Obenshain, M.D.</u>						22d. ADDRESS <u>Cecilton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>OCT. 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION</u>			23d. LOCATION (City, town or county) (State) <u>CHERRY HILL, MD.</u>			
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>						ADDRESS <u>ELKTON, MD</u>		25a. REC'D BY REGISTRAR <u>gcharles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>DATE OCT 31 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14053 CERTIFICATE OF DEATH 14056

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit Rural				c. LENGTH OF STAY IN b Years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. # 1				d. STREET ADDRESS R.F.D. # 1			
3. NAME OF DECEASED (Type or print) Essie Blanche Holliday				4. DATE OF DEATH Month 10 Day 9 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1889	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 07 Days 1		11. IF UNDER 24 HRS. Hours 07 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook Ret.				10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (County & State, or foreign country) Tyler Co. West Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James A. Willers				14. MOTHER'S MAIDEN NAME Elma Ann Mahan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 181-30-3917		17. INFORMANT Mrs. L. B. Gutman Address Port Deposit Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-2, 1966 , to 10-9, 1966 , that (I) (we) last saw the deceased alive on 10-9, 1966 , and that death occurred at 8 M, from the causes and on the date stated above.							
22a. SIGNATURE Neil R. Taylor Jr.						22b. DATE SIGNED 10-11-66	
22c. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr.						22d. ADDRESS Rising Sun, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-66		23c. NAME OF CEMETERY OR CREMATORY Haneyville Cem.		23d. LOCATION (City, town or county) (State) Lock Haven Pa.	
24. FUNERAL DIRECTOR Charles M. Fuller				25a. REC'D BY REGISTRAR Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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R.F.D. # 1

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Miss Ann Mahan

James A. Wallers

181-30-1917 Mrs. L. B. Gorman Port Deposit Md.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14054

14057

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Northampton ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethlehem		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 437 Wyandotte St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CREAD Middle F. Last HYATT				4. DATE OF DEATH Month October Day 6 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 4, 1889		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Micaville N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jayson Hyatt				14. MOTHER'S MAIDEN NAME Sarah McClean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 162-28-3261		17. INFORMANT Henry W. Barnes		Address 437 Wyandotte St. Bethlehem, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 8 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (D) (this hospital) attended the deceased from 4-10 , 19 64 , to Oct. , 19 66 , that (D) (we) last saw the deceased alive on Oct 6 , 19 66 , and that death occurred at 9:30 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Jay S. Barnhart Jr.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-6-66	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.				22d. ADDRESS 4 Mauldin Ave, North East, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/66		23c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		23d. LOCATION (City or Town) (County) (State) North East Cecil Maryland	
24. FUNERAL DIRECTOR Grant Funeral Home				25a. REC'D BY REGISTRAR DATE OCT 10 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14057

CERTIFICATE OF DEATH

14057

Name of Deceased		Date of Birth	
John Doe		1900-01-01	
Sex		Age	
Male		45	
Race		Occupation	
White		Farmer	
Marital Status		Cause of Death	
Married		Heart Disease	
Date of Death		Place of Death	
1945-06-15		Home	
Time of Death		Physician	
10:00 AM		Dr. Smith	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Issuance	
1945-06-16		New York City	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14055											
15521											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Delaware b. COUNTY New Castle ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Newark				46-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital						d. STREET ADDRESS 36 Little Egypt Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Lillian		Middle H.		Last Kyle		4. DATE OF DEATH Month October		Day 27, 19 66	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1919		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Lion						14. MOTHER'S MAIDEN NAME Ada Bailey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT William A. Kyle, Newark, Delaware				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had Stare- Valve Replacement											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 10/14, 1966, to 10/27, 1966, that (I) (we) last saw the deceased alive on 10/27, 1966 and that death occurred at 2:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE J. Randall Ross						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 10/29/66	
22c. PHYSICIAN'S NAME (Type) J. Randall Ross						22d. ADDRESS Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/31/66		23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		23d. LOCATION (City, town or county) Cherry Hill, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Hicks						ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DATE NOV 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

12251

12251



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14056

CERTIFICATE OF DEATH

14058

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b D-O-A		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Havre de Grace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. STREET ADDRESS 812 Juniata Street			
3. NAME OF DECEASED (Type or print) First Middle Last GELARD J. LEADORE						4. DATE OF DEATH Month Day Year October 10 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-18		9. AGE (In years last birthday) yrs. 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Craft Worker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pasquale Leadore (D)						14. MOTHER'S MAIDEN NAME Vincentia Nasone (D)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 215-09-5124		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. (this hospital) attended the deceased from October 10 1966 to October 10 1966 , and that death occurred at 9:30 am from causes and on the date stated above.									
22a. SIGNATURE B. Rothfeld Sr						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-10-66	
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, M.D.						22d. ADDRESS VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/13/66		23c. NAME OF CEMETERY OR CREMATORY Md. Elm		23d. LOCATION (City or Town) (County) (State) Havre de Grace Md.			
24. FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.						25a. REC'D BY REGISTRAR DATE OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14057

CERTIFICATE OF DEATH

14059

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY in 1b 21 days 1 yr 3 mos			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS Rt 3, Box 125		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALVIN H. LEGALL				4. DATE OF DEATH Month Day Year October 20 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-96		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Trinidad BWI		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 10-7-29/5-15-31 553-18-4741		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis, Generalized							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CVA (Stroke--right hemiplegia)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA (this hospital) attended the deceased from July 1 , 19 65 to October 20, 1966 , and that death occurred at 8:45 am from causes and on the date stated above.							
22a. SIGNATURE B Singh M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-20-66	
22c. PHYSICIAN'S NAME (Type) B. SINGH, M.D.				22d. ADDRESS VA Hospital, Perry Point, Md.			
23a. TIME OF REMOVAL (Specify)		23b. DATE THEREOF 10-24-66		23c. NAME OF CEMETERY OR CREMATORY Balt. Nat. Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.				25a. REC'D BY REGISTRAR DATE OCT 25 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14058

14060

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 189 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital				d. STREET ADDRESS Adleigh 5519 Adleigh Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle L. Last Leuschel				4. DATE OF DEATH Month October Day 15 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 22 96		
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender RETIRED			10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS R. Leuschel - deceased				14. MOTHER'S MAIDEN NAME E. GRIMMER Anna Bremer - deceased				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 215-03-05-36		17. INFORMANT VA Hospital Records - Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. -			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 4 8 66 , 19 - , to 10 15 66 , 19 - , the deceased was deceased , and that death occurred at 10:00 am , from causes and on the date stated above.								
22a. SIGNATURE Victor Borges				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-15-66		
22c. PHYSICIAN'S NAME (Type) VICTOR BORGES				22d. ADDRESS VAH Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-15-66		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR WALTER CONKLIN				ADDRESS 5444 Bel Air Road, Baltimore, Maryland		25a. REC'D BY REGISTRAR DATE OCT 19 1966		
				25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14059

CERTIFICATE OF DEATH

14061

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle E. Last Little		4. DATE OF DEATH Month October Day 8 Year 1966	
5. SEX F	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Walker		14. MOTHER'S MAIDEN NAME Ella Deckman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT John E. Little Sr., Perryville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Coronary Artery Disease (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Mr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5 , 19 66 , to 10-8 , 19 66 , that (I) (we) last saw the deceased alive on 10-8 , 19 66 , and that death occurred at 2:45 M, from causes and on the date stated above.			
22a. SIGNATURE G. H. Richards Jr.		22b. DATE SIGNED 10/10/66	
22c. PHYSICIAN'S NAME (Type) G. H. Richards Jr. M.D.		22d. ADDRESS Port Deposit, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-1966	
23c. NAME OF CEMETERY OR CREMATORY Weslvan Chapel Cem.		23d. LOCATION (City or Town) (County) (State) Havre de Grace, Md.	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR OCT 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b Film G303 11/27/66 mm

CERTIFICATE OF DEATH

14060

14062

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 37 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH., Perry Point, Maryland		d. STREET ADDRESS 3004 Lee Highway	
3. NAME OF DECEASED (Type or print) First ROBERT Middle W. Last LIVINGSTON		4. DATE OF DEATH Month October Day 30 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-78
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 88 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) Falmouth, Minn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Livingston (Deceased)		14. MOTHER'S MAIDEN NAME Brittania Smite (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes SAW.		16. SOCIAL SECURITY NO. 229600637	
17. INFORMANT VA Hospital records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Emboli Bilateral with Infarction, Rt Lower Lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 30-60 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 9-23-66 , 19 66 , to 10-30 , 19 66 , and that death occurred at 4:00 PM from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 10-31-66	
22c. PHYSICIAN'S NAME (Type) S. Goldgraben		22d. ADDRESS VAH., Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/3/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Ft. Myers, Va.	
24. FUNERAL DIRECTOR D. E. Seelye IVES FUNERAL HOME Arlington, Va.		25a. REC'D BY REGISTRAR DATE NOV 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14008

RECEIVED 10 MAR 1950

14008

TO: DIRECTOR, ARMY AIR FORCE, WASHINGTON, D.C.
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard memorandum format with fields for TO, FROM, SUBJECT, and a body of text.]

14008
[illegible text]
14008

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14062

14063

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Grove Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Grove Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Grady</u> Middle <u>Marcellus</u> Last <u>Madron</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-07-1910</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Townman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road Comm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Madron</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-16-4196</u>	
17. INFORMANT <u>Mrs. Pearl Madron</u>		Address <u>Liberty Grove, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot-gun wound of head, self-inflicted</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>12-Gauge shot-gun wound, self-inflicted.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:00 a.m. 10-26-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Liberty Grove, Cecil, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byers, M.D.</u> EXAMINER'S NAME (Type) <u>John M. Byers, M.D.</u>		22. DATE SIGNED <u>10-26-66</u> <u>Elkton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Rising Sun Cecil Md</u>	
24. FUNERAL DIRECTOR <u>W. S. Mullen</u>		25a. REC'D BY REGISTRAR <u>Rising Sun</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 31 1966</u>	

14083

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14062

14064

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Earleville				d. STREET ADDRESS Earleville			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Wilson Daniel Maple				4. DATE OF DEATH Month Day Year 10/11/66 19			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/13/1927	
9. AGE (In years lost birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Daniel Maple				14. MOTHER'S MAIDEN NAME Isabell Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-4710		17. INFORMANT Mrs. Gloria Maple		Address Earleville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 8354 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immobilization of chest DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pinned under car					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30p. 10 10 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Balto.-rural Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 10/11/66		22. DATE SIGNED 10/11/66	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 10/15/1966		23c. NAME OF CEMETERY OR CREMATORY Fountain Cemetery		23d. LOCATION (City or Town) (County) (State) Worton, Kent Md.	
24. FUNERAL DIRECTOR Samuel W. Waley				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

19004

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE
HEALTH DEPT**

14063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14065

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East			c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - rural North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rte.40 and Mechanic's Valley Rd.				d. STREET ADDRESS Box 112A R.D.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JEANETTE Janette Middle				4. DATE OF DEATH Month 10 Day 10 Year 1966				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1898		
				9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line Worker			10b. KIND OF BUSINESS OR INDUSTRY Food Canning		11. BIRTHPLACE (State or foreign country) Independence, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Holloway				14. MOTHER'S MAIDEN NAME Mattie Murray				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 221-10-6953		17. INFORMANT Mrs. Halley H. Lake		Address R.D. 1 Box 112A North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 816.1							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in auto-truck collision					
20c. TIME OF INJURY Month, Day, Year 6:05 p.m. 10 10 1966			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 10/11/66		
EXAMINER'S NAME (Type)			Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/66		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Union Cecil Md.		
24. FUNERAL DIRECTOR Grant Funeral Home				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
ADDRESS North East, Md.				DATE OCT 13 1966				

14039

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14066

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East		c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.-rural North East 07/1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rte. 40 and Mechanic's Valley Rd.				d. STREET ADDRESS Box 112A R.D.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Vernon McCreary				4. DATE OF DEATH Month Day Year 10 10 19 66			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1894		9. AGE (In years last birthday) yrs. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin McCreary				14. MOTHER'S MAIDEN NAME Sara Jane Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 710-09-6982		17. INFORMANT Mrs. Halley H. Lake Address R.D. 1 Box 112A North East, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8161 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver in auto-truck collision					
20c. TIME OF INJURY Month, Day, Year Hour 6:05 p.m. 10 10 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) street		20f. CITY OR TOWN (County) (State) Balto.-rural Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 10/11/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/66		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Union Cecil Md.	
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS North East, Md.		25a. REC'D BY REGISTRAR OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

14000

14000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14067

FOR STATE HEALTH DEPT.

14065

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Conowingo</u>		c. LENGTH OF STAY IN lb <u>28 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R.D. 1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Osborne</u> Middle <u>Mulligan</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-97</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper - Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Sales</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice Mulligan</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-32-9596A</u>	
17. INFORMANT <u>Mrs. Rosie Mulligan, Conowingo, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John M. Byers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Elkton, Md.</u>	
22. DATE SIGNED <u>10-5-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10-8-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Peachbottom Lancaster Pa.</u>
24. GENERAL DIRECTOR <u>John M. Muller</u>	ADDRESS <u>Rising Sun Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1911

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14066

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Earleville		c. LENGTH OF STAY IN TOWN 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilma Alberta Mullins		4. DATE OF DEATH Month 10 Day 31 Year 1966	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) OKla.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stewart		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 444-26-9574	
17. INFORMANT Mr. Logie Mullins, Earleville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO (b) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John M. Byers, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 10-31-66 E. K. Jones, M.D.			
23a. BURIAL, CREMATION, or other (Specify) Burial	23b. DATE THEREOF Nov. 4, 1966	23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	23d. LOCATION (City or Town) (County) (State) Cecilton, Cecil, Md.
24. FUNERAL DIRECTOR Edward Fellows,		25. REC'D BY REGISTRAR DATE NOV 4 1966	
ADDRESS Millington, Md. 21651		25b. REGISTRAR'S SIGNATURE Charles Judge	

80011

0001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Hudon	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 4 mos 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH, Perry Point, Maryland		d. STREET ADDRESS 334 S. Rogers Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARIE A. PARADIS		4. DATE OF DEATH Month Day Year OCTOBER 12 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-05
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Holyoke, Mass		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT PARADIS		14. MOTHER'S MAIDEN NAME DELIA AUBREY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 017206951	
17. INFORMANT VA RECORDS VAH, PERRY POINT, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant lymphoma (lympho sarcoma) 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VAH (this hospital) attended the deceased from 5-19 , 1966, to 10-12 , 1966, that the deceased saw the deceased alive on and that death occurred at 5:15 PM from causes and on the date stated above.			
22a. SIGNATURE J. Reus/B.R.		22b. DATE SIGNED 10-13-66	
22c. PHYSICIAN'S NAME (Type) IRINA REUS, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 17 Oct 66	
23c. NAME OF CEMETERY OR CREMATORY Notre dame Cem.		23d. LOCATION (City or Town) (County) (State) South Hadley Falls, Mass	
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Maryland		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14003

14003

tail-point lymphoma (lympho sarcoma)

14 years

x 10-15-66

VAN, Perry Point, Md.

LADIA HUB, N.D.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14068

CERTIFICATE OF DEATH

14070

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 30 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) No. 4 Mauldin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NINA Middle MATILDA Last PRICE		4. DATE OF DEATH Month October Day 7 Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Home	
12. BIRTHPLACE (County & State, or foreign country) North Carolina		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME No Info.		15. MOTHER'S MAIDEN NAME No Info.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. SOCIAL SECURITY NO. 171-24-6783	
18. INFORMANT Mrs. Pauline Dickens		Address R.D. 1 Elkton, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO (c) Arteriosclerotic cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-24 , 19 63 , to 10-7 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-7 , 19 66 , and that death occurred at 11:55 PM , from causes and on the date stated above.			
22a. SIGNATURE Jay S. Barnhart Jr.		22b. DATE SIGNED 10-8-66	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.		22d. ADDRESS No. 4 Mauldin Ave. North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/66	
23c. NAME OF CEMETERY OR CREMATORY Harmony Rd. Burial Grounds		23d. LOCATION (City or Town) (County) (State) West Grove Chester Penna.	
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE OCT 11 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Page please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Alleghany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 25 days 1 yr 1 mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 700 Baker Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES P. RANEY JR.		4. DATE OF DEATH Month Day Year October 17 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-96
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bowling Alley Operator Recreation		10b. KIND OF BUSINESS OR INDUSTRY Recreation	
11. BIRTHPLACE (County & State, or foreign country) Kensington, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James P. Raney (D)		14. MOTHER'S MAIDEN NAME Mary Ann Curtin (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-09-7918	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive hemorrhagic infarct of brain (c) Thrombosis of left internal carotid artery		INTERVAL BETWEEN ONSET AND DEATH 5-10 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from August 25, 19 65 , to October 17, 1966 , that the deceased died on October 17, 1966 , and that death occurred at 6:20 PM , from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 10-18-66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Bur.		23b. DATE THEREOF 10/21/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Kensington, Md.		25a. REC'D BY REGISTRAR OCT 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11008

Party - Inc

1 yr 1 mo
55 days

Hammerland

Hammerland

300 Baker Street

Veterans Administration Hospital

JAMES W. P.

BARNEY JR.

October 17

55 50

11-28-54

White

Male

Bowling Alley Operator, Recreation

Kennelwood, Maryland

James F. Barney

(D)

Hammerland (D)

WA I

853-05-7018 VA Hospital, Army Point, Md.

VA Hospital, Army Point, Md.

Tracheo esophageal fistula

3-10 days

Massive hemorrhagic infarct of brain

Unknown

Thrombosis of left internal carotid artery

Unknown

XXXXXXXXXXXXXXXXXXXX

6:30 pm

10-18-56

VA Hospital, Army Point, Md.

VA Hospital, Army Point, Md.

Removal - VA Hospital, Army Point, Md.

Thyroid gland removed, Army Point, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film G381 10/20/66 mh

14070

CERTIFICATE OF DEATH

14072

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 yr. 10 mo 12 days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 515 16th St., N. W.	
3. NAME OF DECEASED (Type or print) John J. REESE		4. DATE OF DEATH Month October Day 7 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 15 94
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (County & State, or foreign country) Scranton, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Reese - deceased		14. MOTHER'S MAIDEN NAME Rachel Moses - deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 230-18-55-24	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema acute DUE TO (b) Calcific Aortic Stenosis DUE TO (c) Emphysema, Bullous, Obstructive, Severe			INTERVAL BETWEEN ONSET AND DEATH 1-3 days Years -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 11-25-64 , 19 64 , to 10 7 66 , 19 66 , and that death occurred 10:55 M, from causes and on the date stated above.			
22a. SIGNATURE L. Von Muehlen		22b. DATE SIGNED 10 8 66	
22c. PHYSICIAN'S NAME (Type) L. VON MUEHLEN, M.D.		22d. ADDRESS VAH PERRY POINT, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 10 8 66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Ft Myer, Va.
24. FUNERAL DIRECTOR PENNINGTON & SON - Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
ADDRESS PENNINGTON & SON - Havre de Grace, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
14071									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					d. STREET ADDRESS Elk Neck			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia May Rhoades			4. DATE OF DEATH Month Day Year Oct 17 19 66						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1916		9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Dill					14. MOTHER'S MAIDEN NAME Katie Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 219-42-7695		17. INFORMANT M. Richard Rhoades Address Galena, Md. Daughter - Joyce Loackard				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aneurysm of Middle Cerebral artery 7 hr 330x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 7 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Apr 4, 1965, to 17 Oct, 1966, that (I) (we) last saw the deceased alive on 17 Oct 19 66 and that death occurred at 3:15 PM from the causes and on the date stated above.									
22a. SIGNATURE Wallace Obenshain					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 18 Oct 66		
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.					22d. ADDRESS Cecilton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town or county) (State) Bethel, Maryland		
24. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME, Inc./W. R. Elkton, Md.					25a. REC'D BY REGISTRAR DATE OCT 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14072					14074				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Cecil</u> MARYLAND					a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Port Herman</u>				
c. LENGTH OF STAY IN 1b <u>3 days</u>					d. STREET ADDRESS <u>R.D. #1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Rachael A. Salicone</u>			First Middle Last		4. DATE OF DEATH <u>Oct. 10, 1966</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1882</u>		9. AGE (in years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Selbeville, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Barker</u>				14. MOTHER'S MAIDEN NAME <u>No info.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>192-24-1495B</u>		17. INFORMANT <u>Daniel Salicone Port Herman, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>578 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTESTINAL HEMORRHAGE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7</u> , 1966, to <u>Oct 10</u> , 1966, that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 1966, and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Henry V. Davis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/10/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS</u>				22d. ADDRESS <u>CHESAPEAKE CITY MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chesapeake City, Md.</u>			
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>Downy Rd Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14073

CERTIFICATE OF DEATH

14075

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALFRED N. SATTERFIELD		4. DATE OF DEATH Month Day Year October 24 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-86
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Pringting Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Satterfield (D)		14. MOTHER'S MAIDEN NAME Johanna Mitchell (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 579-05-2604	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema (congestive heart failure) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized years		INTERVAL BETWEEN ONSET AND DEATH 4-7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Sept. 30 , 19 66 , to Oct. 24 , 19 66 , and that death occurred at 1:45 pm from causes and on the date stated above.			
22a. SIGNATURE Balbir Singh M.D.		22b. DATE SIGNED 10-25-66	
22c. PHYSICIAN'S NAME (Type) BALBIR SINGH, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Oct 26/1966	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Pennington & Son Funeral Home, Havre de Grace, Md.		25a. REC'D BY REGISTRAR OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14074

CERTIFICATE OF DEATH

14076

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.		d. STREET ADDRESS 717 Hodgson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thurber L. SMOCK		4. DATE OF DEATH Month Day Year October 12 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-99
9. AGE (In years lost birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State, or foreign country) Kussuth County, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Davis Smock (D)		14. MOTHER'S MAIDEN NAME Alice Gregory (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-22-5037	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post-op status for partial gastrectomy ulcer) DUE TO (c) Massive gastric hemorrhage (bleeding marginal		INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 days 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver, old infarct of spleen		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 10-7-1966, to 10-12-1966, that the deceased died on 10-12-1966, and that death occurred at 3:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE J. P. Blawie		22b. DATE SIGNED 10-12-66	
22c. PHYSICIAN'S NAME (Type) JOEL BLANCAFLOR, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-15-66	
23c. NAME OF CEMETERY OR CREMATORY Oxford		23d. LOCATION (City or Town) (County) (State) Oxford, Pa. P.A.	
24. FUNERAL DIRECTOR Douglas Woodworth		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14077

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Elkton</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>Oldfield Pt., R.D. 1, Elkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Chauncey Judd Stewart</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker - Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Judd Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>Yes World War II Navy</u>		16. SOCIAL SECURITY NO. <u>222-10-1344</u>	
17. INFORMANT <u>Mrs. Margaret Stewart, R.D. 1, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byers, M.D.</u>		22. DATE SIGNED <u>10-23-66</u> <u>Elkton, Md.</u>	
EXAMINER'S NAME (Type) <u>John M. Byers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>10/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SILVERBROOK CREMATORY</u>	23d. LOCATION (City or Town) (County) (State) <u>WILMINGTON, N.C. Del.</u>
24. FUNERAL DIRECTOR <u>Albert J. McCray, Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>2200 WASH. STREET</u>		DATE <u>OCT 27 1966</u>	

1103

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14078

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Elkton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 119 Collins Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 119 Collins Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCIS ANTHONY THOMAS		4. DATE OF DEATH Month October Day 5 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/23
9. AGE (In years last birthday) 43		10. IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min. 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Thomas		14. MOTHER'S MAIDEN NAME Addie M. Francis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-14-8803	
17. INFORMANT Addie M. Thomas-135 Collins St.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED October 6, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/66	
23c. NAME OF CEMETERY OR CREMATORY Providence Cem.		23d. LOCATION (City or Town) (County) (State) Elkton, Maryland	
24. FUNERAL DIRECTOR Edw. K. Bell ADDRESS 909 Poplar St.		25a. REC'D BY REGISTRAR OCT 10 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14077											
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>						c. LENGTH OF STAY IN 1b <u>CHESAPEAKE CITY, MD. 07-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DELAWARE AVE.</u>						d. STREET ADDRESS <u>DELAWARE AVE.</u>					
3. NAME OF DECEASED (Type or print) <u>LAURA L. WATSON</u>						4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/82</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEAR CHESAPEAKE CITY U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ROBERT DONALDSON</u>						14. MOTHER'S MAIDEN NAME <u>ROSE PRICE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>IRMA W. REYNOLDS</u>		17. INFORMANT <u>IRMA W. REYNOLDS</u> Address <u>CHESAPEAKE CITY, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized debility</u> DUE TO (c) <u>Generalized arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Rolando A. Najera</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. NAJERA</u>						22b. DATE SIGNED <u>10/25/66</u>					
22d. ADDRESS <u>105 E. MAIN ST, ELKTON, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY, NR CHESAPEAKE CITY, MD.</u>				23d. LOCATION (City, town or county) (State) <u>ELKTON, MD.</u>			
24. FUNERAL DIRECTOR <u>Robert Pippin</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
ADDRESS <u>PIPPIN FUNERAL HOME 7000 ELKTON, MD.</u>						DATE <u>OCT 27 1966</u>					

14030

CERTIFICATE OF DEATH

130

1
FOR STATE
HEALTH DEPT.

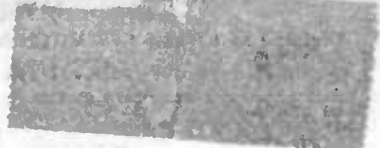
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14078

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>4</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW YORK</u>		d. STREET ADDRESS <u>201 W. 112th ST NEW YORK NY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>V.A. Hosp Perry Point Md.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PERCY D WATSON</u>		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1966</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-21</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HEZEKIAH WATSON</u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>1942-1945</u>		16. SOCIAL SECURITY NO. <u>242-24-1814</u>		17. INFORMANT <u>Perry Point Hosp. Records</u>		Address <u>Perry Point Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EPILEPSY-10YRS CANONICAL SEIZURES - GASTRIC HEMORRHAGE</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL ON STREET</u>					
20c. TIME OF INJURY Hour <u>5</u> p.m. <u>10/2</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>		20f. City or town <u>NEAR HOURS DEGRACE MD</u>	
20g. (County) <u> </u>		20h. (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>		DEPUTY MEDICAL EXAMINER <u> </u>		DATE SIGNED <u>10/6/66</u>		Address (Street, city, town, or county) <u>ONESA WAKECITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		22b. DATE THEREOF <u>10/10/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Raleigh, North Carolina</u>	
23. FUNERAL DIRECTOR <u>PATTERSON FUNERAL HOME, Perryville, Md.</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>gcharles Judge</u>	

MEDICAL CERTIFICATION



1980

[The following text is mirrored bleed-through from the reverse side of the page and is largely illegible due to fading and orientation.]

STATE OF NEW YORK
IN SENATE
January 1, 1980

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ON THE
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ON THE
ANNUAL REPORT OF THE
OFFICE OF THE COMPTROLLER OF THE STATE

COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES
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